Richard L. Gilbert
Judge of the Superior Court, Retired
Resolution Arts Building
2630 J Street
Sacramento, Calif. 95816
Tel (916) 442-0414/Fax (916) 442-7046
www.rgilbertadr.com

Richard L. Gilbert
Judge, Retired

Amanda C. Gilbert
Attorney at Law

Medicare "Set-Aside" Requirements in Third Party Liability Cases

Panic: No/Prepare: Yes

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Are the rumors true? Is it necessary to create "Medicare Set-Aside Accounts" in third party liability (not Workers' Compensation) Cases? What are you talking about, anyhow? These are questions that have been floating in and out of my head recently after hearing "rumors" that there were amendments to Federal Medicare laws effective July 1, 2009 that would require provision to "protect" Medicare's future interests by, for example, creating Medicare Set- aside Accounts ("MSA") in third party liability cases.

With some help from my friends[1] and some independent research, I have concluded there is an answer to the question whether MSAs are needed in third party liability cases:

> "Probably not, but sometimes you should do it anyhow." Most importantly however, you should determine the possibility of the need for a set aside early and prepare for that need in advance of settlement discussions, particularly mediation.

Let me explain; from the almost beginning.

Background

To understand the issue, it is necessary to understand that Medicare paid health benefits are, by virtue of Federal law, "secondary" to other available healthcare funding

[1] I extend particular thanks to David J. Korch, *National Director of Workers' Compensation Services*, EPS Settlement Group, Inc., for the direction and insight provided by his presentation on this subject in Sacramento, California on June 1, 2009. Where specific reference is made here to particular observations by David, the reference will be to "Korch". Like other major structured settlement brokers, EPS has extensive experience with the Workers' Compensation model and is gearing up to deal with the potentially emerging issues of set asides in the third party liability field.

sources.[2] This means that Medicare's obligation to provide benefits kicks in only when "primary" sources of coverage are exhausted for an otherwise Medicare eligible beneficiary.

Primary sources of funding, "primary payers" include Workers' Compensation programs as well as insurers and self-insured entities obligated to provide payment for health care costs by virtue of third party claims against the insured or self-insured entities.

Several things flow from this fundamental proposition and other specific statutory enactments:

- First, Medicare has a "lien" against any proceeds from a judgment or settlement to the extent that Medicare paid for any health care to the injured party.[3]

- Secondly, Medicare requires that its interests be "taken into account" in any judgment or settlement regarding future health care costs.

We are fairly used to dealing with Medicare "liens" and, in that connection, CMS.[4] The liens are statutory and notice of the lien is not required.[5] I'll pass on further discussion about liens. Unless you have experience in the Worker's Compensation ("WC") field, however, you are probably not used to dealing with protecting Medicare's interests with respect to future medical care costs.

For many years, Workers' Compensation settlements have needed to take into account the potential that the settling claimant is or will likely become a Medicare beneficiary.

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[2] Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii), Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

[3] 42 U.S.C. § 1395y(b)) not only establishes that Medicare is a secondary payer to WC, but also that Medicare has a priority right of recovery over any other entity to the proceeds of any settlement. To the extent that Medicare has made any "conditional payments", Medicare recovers those payments pursuant to 42 C.F.R. § 411.47. This is the familiar Medicare lien. (See 42 C.F.R. 411.52 regarding third party cases.).

"Conditional payments" are Medicare payments for services for which another payer is responsible, made either on the bases set forth in 42 C.F.R. § 411 subparts C through H, or because the intermediary or carrier did not know that the other coverage existed. (42 C.F.R. § 411.21)

[4] "CMS" is the "Centers for Medicare & Medicaid Services", formerly "HCFA", the "Healthcare Finance Administration", which administers the Medicare program. You have dealt with CMS in working to obtain lien information and resolve liens.

[5] Medicare has a statutory first right of recovery against all proceeds (42 U.S.C. 1395y(b). Unlike, for example, hospital lien rights in California where notice is required to perfect the lien (Civil Code §3045.3; *Parnell v. Adventist Health* (2005) 35 Cal.4th 595, 601-602), the "right of recovery" is not a "lien" in the technical sense requiring notice.

Where the case meets the required "threshold"[6], an amount of money should be "set aside" from the settlement proceeds to account for future medical costs that Medicare would otherwise have to bear.[7] Only when that amount has been properly exhausted, will Medicare then become obligated to provide coverage as the primary payer. It is in this way that Medicare's role as the secondary payer is preserved. These MSAs take the form of bank or similar depository or investment accounts funded at the time of settlement either with cash or through periodic annuity payments to the MSA. The amounts put into the MSA can and should be approved by CMS.

What's New

The laws pertaining to Medicare's status as the secondary payer – "MSP" in the trade, or "Medicare Secondary Payer" – have not changed since the 1980's. Medicare has been a secondary payer with respect to Workers' Compensation since the beginning of the program in the mid-1960s. What happened in 2007, is that the Medicare law was changed to require that insurers, self-insureds and others not pertinent here, are now required to report third-party liability claims and settlements to CMS.[8] These law

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[6] "It is not in Medicare's best interest to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. **(Ref: 7/23/01 Memo Q1(c))** A WCMSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

A WCMSA may be submitted to CMS for review in the following situations:

- The claimant is currently a **Medicare beneficiary** and the total settlement amount is **greater than $25,000**; **OR**

The claimant has a "reasonable expectation" of Medicare enrollment **within 30 months of the settlement date** and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be **greater than $250,000**."
(See the CMS website page concerning WC set asides:
http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage (emphasis in original)

[7] The burden of future medical expenses in WC cases may not be shifted to Medicare. 42 C.F.R. §§ 411.46 and .47 provide that Medicare's interest must be considered in WC settlements, when future medical expenses are a component of the settlement.

The CMS website notes, "Because Medicare does not pay for an individual WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in the best interest of the individual to consider Medicare at the time of settlement. For this reason, CMS recommends that parties to a WC settlement set aside funds, otherwise known as Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) for all future medical services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare."

[8] 42 U.S.C. 1395y(b)(7) and (b)(8) (See, United States Code, TITLE 42 — THE PUBLIC HEALTH AND WELFARE, CHAPTER 7 — SOCIAL SECURITY, SUBCHAPTER XVIII — HEALTH INSURANCE FOR AGED AND DISABLED, PART E — MISCELLANEOUS PROVISIONS, 42 U.S.C. § 1395y. Exclusions

changes did not, however, enact requirements for MSAs in third party liability cases. "Why worry", you say. Maybe you shouldn't; but read on.

Those of you into legal research will not find a specific statutory or regulatory basis for requiring MSAs in Comp cases; yet they are common and expected/required by Medicare.[9] Industry experts note that the evolution of MSAs in WC cases stems in great part from the insurance industry's reaction to the requirement that Medicare's interests be considered in WC settlements including future medical care. Fearing their potential liability to Medicare by not specifically earmarking dollars for future care and setting them aside, the industry began the practice of demanding set asides. Also, it appears that CMS has an interesting take on the hierarchy of law governing the Medicare process. As Korch puts it, there are statutes, then regulations, then Medicare memos and, then, there are times where CMS changes how they interpret the memos. An attempt to reconcile the formal "guidance" on the CMS website with specific U.S.C. and C.F.R. references will demonstrate the accuracy of that characterization.

This leads to the inevitable question of whether, despite the absence of specific statutory or regulatory mandate, set-asides will, nonetheless, be required in third party liability cases. Let me duck the question one more time and mention what is going on at CMS with respect to the 2007 amendments in section 111, the reporting requirements.

CMS is in the process of developing an electronic data based information reporting program ("EDI") as mandated by the statute. The details of this program are still being developed and the insurance industry is participating. The implementation dates have been pushed back several times. At present, testing of the reporting protocols is to take place between April 1 and June 30, 2010. The go-live implementation is anticipated between July 1 and November 31, 2010. When the system does go live, however, it is expected that "Required Reporting Entities" ("RRE") will report on claims and settlements from and after July 1, 2009. Accordingly, carriers and self-insureds are to be collecting data on all claims from and after July 1, 2009 for later reporting. [10]

When you peruse the CMS website, as, indeed, you must (thrilling romantic, etc…..), you will see that CMS is hosting a series of telephonic "town hall meetings" to receive input, answer questions and disseminate information on the policy and EDI aspects of the program. Transcripts of the sessions are posted on the site. During the October 29, 2008 session, the following question and answer were exchanged:

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from Coverage and Medicare as Secondary Payer.) The recent amendments are found in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). You will references to "Sec. 111" on the CMS websites cited here.

[9] See note 7, supra.

[10] Korch; and see the CMS website.

"Next question comes from (Loren F.). Thank you. Your line is open.

(Loren F.): Hi I'm a lawyer. And my question - and this may not be the right forum for it but the most recent General Counsel Memoranda that I saw talked about the coordination of benefits and Medicare (certified) and so on only applies to worker's comp. And then, of course, you had the SCHIP Extension Act which extended the information reporting to the third party liability claims and so on.
And it seems informally that in some cases they're seeking to do coordination of benefits with third party claims that aren't worth (their) time. And sometimes they're not. Do you guys have any insight on that as to whether we need to make set aside arrangements and coordination of benefits for ordinary auto accident or medical malpractice or so on...

(Barbara) Wright: First of all, excuse me, first of all I don't believe there is a General Counsel Memo that says that there are no liability set asides. We, in brief, we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for worker's comp.
In either case CMS approval of a set aside amount is not required. It is a voluntary process.

(Loren Friedman): Right.

(Barbara) Wright: And lastly Section 111 does not mandate or specify anything about liability set asides. So no that isn't really a topic for right now."[11]

Having read that, you are probably thinking, "Gilbert, thinking about Medicare gives me a headache. Medicare says set asides aren't needed in third-party cases. Why are you making me read this"?

Fair question. First of all, remember that Workers' Comp. set asides "aren't required either" - but they are. Secondly, consider what happens if Medicare's interests are not considered at the time of settlement – the beneficiary (the client if you are a plaintiff's attorney) can lose entitlement to benefits.[12] If you are a plaintiff's lawyer, who do you think the client will call first when he or she finds out his or her benefits are cut off because settlement proceeds weren't applied to offset future Medicare covered health care costs? Carriers need to be concerned about potential liability for not considering Medicare's interests as well.[13] Finally,

[11] See, http://www.cms.hhs.gov/MandatoryInsRep/Downloads/TeleconfOct2908.pdf (FTS-HHS HCFA Moderator: John Albert 10-29-08/12:00 pm CT, Confirmation # 1211627, pages 17-18, emphasis added.)
[12] See 42 C.F.R. 411.50 regarding limitation of benefits where primary payer source available..
[13] There are specific statutory penalties for not reporting (42 U.S.C. 1395y(b)8(E)), but there is no

remember that CMS will soon begin to know about claims and settlements so this may not be purely theoretical.

What to do.

Pre-Settlement/Mediation

The first panic I experienced when hearing of the possibility of needing MSAs in third party liability cases was that the fear that the requirement could make it very difficult to expeditiously settle major loss cases with Medicare involvement during the mediations I conduct. If the parties were not prepared to address the issue, I feared the negotiations would inevitably stall. Even if the parties were ready, the notorious non-responsiveness and delays in dealing with CMS appeared as a possible show stopper. This should not be the case. The trick: be a Boy Scout, "Be Prepared".[14] Here are some thoughts, organized by reference to the particular "player", plaintiffs' lawyers, defense lawyers, claims representatives and "everyone".

Everyone:

The first step that everyone needs to take is to make at least a preliminary assessment whether the case is one where an MSA may be required in the first instance.

Korch and others suggest, and I strongly endorse, that the answer to the question should be made on a case by case basis depending on the amounts involved and associated risk factors.

First, the issue should only arise in the case of current Medicare beneficiaries or, at most, those who have applied for or are actually eligible for Medicare at the time of settlement. Recall that CMS only wants to look at WC MSAs that meet certain threshold criteria, $25,000 for current beneficiaries and $250,000 lifetime total where beneficiary status is likely within 30 months.[15] There should be a difference with respect to third party cases as, unlike in WC, those third party cases do not involve a payer's lifetime obligation for medical care relating to the adjudicated injury as does WC in most states (including California). *Accordingly, current beneficiary status should be the first test with respect to whether a set aside should be considered*.

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articulated basis for recovery of Medicare expenditures from an RRE where there was no set aside and Medicare pays future costs that could have been paid through an MSA. Query: how long before CMS finds the deep pocket?

[14] Not as Tom Lehrer advised, however.

[15] See note 6, supra.

The next step should be to consider the risk posed to the client, plaintiff, or payer ("RRE" - insurer or self-insured entity), from not explicitly dealing with Medicare's future interest through a set aside. A small settlement, whether or not involving future medical care, poses less risk. The larger the case, and the larger the component of future medical expenses involved in the value, the greater the risk. Also, the availability of other coverage for future medical expenses is a reasonable factor.

As you will see from the separate player notes below, a primary key to managing the issue successfully is early communication among the players.

Defense Counsel and Claims Adjusters:

● Be aware of the carrier/self-insured (both, "carrier" for convenience hereafter) policies concerning provision for MSA in third party cases.

- does the carrier ever require a set aside?
- does the carrier have in-house or contracted vendor relationships to analyze future health care costs, set up MSAs and/or seek CMS review and approval?
- what is the carrier viewpoint on the use of annuities to fund MSA?
- does the carrier have a preferred annuity broker or carrier if needed?
- will the carrier pay the cost of analyzing future care costs, setting up an MSA and seeking CMS review?

● Do you have all current medical records?

● Consider a "pre-review" of projected future medical costs.

● Be sure plaintiff's counsel is aware of carrier expectations in advance of settlement discussions/mediation.

● Find out the plaintiff's Medicare status- current beneficiary? Eligible? Do you have the plaintiffs Social Security number to check SSI, etc, status? Will Plaintiff's counsel provide that information for that purpose?

● If an MSA is in the picture, is an annuity a good way to go? If so, get cost estimates and consider having a broker at the mediation; coordinate with plaintiff's counsel.

Plaintiff's Lawyers:

- What is the client's Medicare status – current beneficiary? Eligible? Receiving SSI?

- Be sure you know what alternate health insurance payer sources, if any, are available to the client.

- Be sure you have all medical records.

- If you might do a "life care plan", consider doing it earlier rather than later so that future health care costs can more readily be identified.

- Find out what the carrier's position is on MSA.

- Consider having future care costs analyzed in advance of mediation by a suitable service.

- If an MSA is in the picture, is an annuity a good way to go? If so, get cost estimates and consider having a broker at the mediation; coordinate with defense counsel.

Options to Satisfy MSP/MSA Requirements

With as much information as possible in hand, consider that the range of risk suggests a range of options:[16] Here are some options to look at:

1. Make no provision. Based on the absence of statutory, regulatory or administrative directive or guidance, this option may be sound, especially in "small risk" cases.

2. Explicitly account for Medicare's interests and the beneficiary-plaintiff's obligations with respect to exhaustion of settlement proceeds allocable to Medicare covered future costs in the settlement agreement.[17] Consideration should also be given to allocating the total settlement amount to its various components, including a separate reasonable allocation to future medical expenses.[18]

[16] Once again, specific credit for suggesting this range of options to me initially goes to EPS and Korch.
[17] EPS MediSolutions© has obtained an opinion letter from a nationally prominent law firm concerning this approach. EPS can assist its clients in obtaining a reliance opinion from the firm at a reduced cost. Other structure companies may offer similar accommodations.
[18] We have sample language available for settlement agreements reached during mediations with us. Note that the allocation suggested here is much the same as allocating settlement proceeds where part of the recovery is past or future lost income. An allocation is always wise for tax purposes in that setting.

3. Make a determination of estimated future medical costs. This can be done as part of an allocation within the settlement agreement, with or without establishing a set aside account. What this means and suggestions on how to do it are discussed below.

4. Create a Medicare Set Aside account. Based on the estimated future medical costs and the projected timing of funding needs, this can be done through cash funding or through an annuity, or both. Where medical expenditures extend over some time, it has been estimated that the cost of funding by annuity as opposed to cash averages 48%.[19] This savings can make the difference between settlement and no settlement. MSA accounts can be self administered or professionally administered. This is discussed a bit more, below.

5. Seek CMS approval of the MSA. This is the crowning step. Based on current "intelligence", discussed, above, it is now more than likely that CMS will decline to review and approve the MSA. Even if that happens, there is, at least, a record of the good faith efforts to consider Medicare's interests at the time of settlement.

This discussion is not intended as a detailed "how to" with respect to estimating future medical costs, setting up MSA accounts, or obtaining CMS approval of an MSA, but here are some thoughts to get you on the way.

There are several approaches to estimating future medical costs.[20] If you have prepared a life care plan in the case already, the calculations can be made from that base. There are also services that can adapt the life care plan to a future cost estimate with a covered v. non-covered breakdown. If there is no life care plan, existing medical records and reports will need to be analyzed and an estimate prepared. Here, again, there are services available to do this, either stand alone or as a package with other MSA related activities.[21]

As suggested, the MSA account can either be self-administered or managed

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No allocation and the IRS makes the call. Likewise, an unreasonably low allocation will be ignored. Approach the allocation of Medicare covered future costs in the same way and, if possible, have a basis for the allocation "in the file".

[19] Korch.

[20] This calculation should also include analysis of which of the future costs are covered by Medicare.

[21] For example, EPS has "partnered" with a firm called "Medivest" to offer a package of services from future cost analysis, establishment and administration of MSA accounts, obtaining CMS review and brokering any needed funding annuity.

professionally by a service. The key here is to assure and have evidence that the funds are directed to health care costs that would otherwise be covered by Medicare so that, when the funds are properly exhausted, Medicare will agree that their interests have been considered and they will step in as primary payer and resume coverage.[22]

Submission to CMS may also best be done by a reputable service provider. Be aware, also, that CMS turnaround times are notoriously slow, up to 6 months in WC experience, if reviewed at all.

Pre- and Post-Trial

As you will see from the statutory and regulatory citations above, accounting for Medicare's interest is required both respect to settlements and judgments. Accordingly, strategies need to be considered to manage the issue in applicable cases that go to trial.

All of the preparatory steps noted above should be on your radar. The end game, however, is a bit different. To consider Medicare's interests with respect to future medical care costs awarded as a part of judgment will require that, in some fashion, the portion of the judgment amount representing Medicare covered future costs be identified. An obvious first instinct would be to present specific evidence of the break-out at trial and have a corresponding special verdict completed by the jury. This sounds awfully distracting and cumbersome to me, however.

Another thought is that the issue be dealt with in a post-judgment hearing akin to a post-verdict *Greer*[23] determination. In that setting, the court can be presented with the future medical care costs and the Medicare-covered cost breakout and issue a judicial determination. That determination can form the basis of an MSA or other provision for "Medicare's interests". Even if an MSA is not established because the case is "low risk", the process may be sufficient proof that Medicare's interests were considered. If there is not an MSA, however, be sure the plaintiff knows what his or her obligations as a beneficiary are with respect to the value of Medicare covered future health care costs included in a judgment. A final note: for the reasons discussed above, doing something along these lines should be a common interest of both the plaintiff and defense.

[22] There are lots of details about this, including, for example, the accounting periods for exhaustion and expectations for fund replenishment in annuity funded MSA arrangements.

[23] *Greer v. Buzgheia* (2006)141 Cal.App.4th 1150 (2006) 46 Cal.Rptr.3d 780. Greer held that a plaintiff may produce evidence of the reasonable value of medical care costs before the jury, even if paid medicals were less and that the defense can move, post-verdict, for a reduction based on proof of the write-downs.

Conclusions

The comments above should convince you that the world has not ended. The simple message is this: be aware of the issue and prepare, in advance, to deal with it. It seems to me that you really won't be dealing with the MSA issues in third-party cases for the foreseeable future except in larger cases with significant future medical costs with current Medicare beneficiaries. The preparation suggested here, all to be done in advance of settlement discussion, particularly mediation, and trial are likely things you would want to do in any event. A final thought: keep your eyes and ears open for changes on the horizon.